

# STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR AFDC-EXTENDED FOSTER CARE (EFC)

**INSTRUCTIONS:** *Nonminors entering EFC after an absence from care shall complete in ink all questions to the left of the heavy black line. The Nonminor completes the non-shaded sections of this form instead of the BCJA 2 or SAWS 2; the placement worker/county welfare department is to complete the shaded portions.*

Completed by the Nonminor (NM)

<b>1.</b> NAME OF NM	<b>2.</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<b>3.</b> PLACEMENT ADDRESS	<b>3A.</b> PHONE
<b>4.</b> CURRENT ADDRESS (IF DIFFERENT FROM PLACEMENT ADDRESS)	<b>5.</b> PHONE
<b>6.</b> BIRTH DATE	<b>7.</b> BIRTHPLACE
<b>8.</b> SOCIAL SECURITY #	<b>9.</b> APPLIED FOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>10.</b> CITIZEN OF U.S.? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>11.</b> ALIEN STATUS:
<b>12.</b> DO YOU HAVE MEDICAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LIST POLICY NUMBER, COMPANY NAME, AND NAME OF POLICY:	
<b>13.</b> DO YOU HAVE REAL OR PERSONAL PROPERTY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LIST PROPERTY TYPE (LAND, CASH, AUTO, MOTORCYCLE, LIFE INSURANCE, TRUST FUND, BANK ACCOUNT, BOND, ETC.) AND ITS VALUE:	
<b>14.</b> DO YOU HAVE INCOME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LIST AMOUNTS BELOW. IF APPLICATION PENDING, CHECK ASSOCIATED BOX.	

Income Type	Amount	Pending
SOCIAL SECURITY (SSA OR SSI/SSP) CIRCLE ONE		<input type="checkbox"/>
CHILD SUPPORT		<input type="checkbox"/>
UNEMPLOYMENT BENEFITS		<input type="checkbox"/>
PENSIONS		<input type="checkbox"/>
DISABILITY (STATE WORKMAN'S COMPENSATION, ETC)		<input type="checkbox"/>
IN-KIND INCOME (FREE RENT, UTILITIES, FOOD)		<input type="checkbox"/>
SALARY/WAGES		<input type="checkbox"/>
SCHOLARSHIP/GRANTS		<input type="checkbox"/>
OTHER		<input type="checkbox"/>

IF EARNED INCOME: NAME OF EMPLOYER:  
  
 ADDRESS:  
  
 WORK HOURS/MONTH:

## ELIGIBILITY WORKER ONLY

DATE:

☐ APPLICATION FOR RE-ENTRY  
☐ REDETERMINATION

CASE NAME

CASE NUMBER

## VERIFICATION

Former Foster Care Status

Termination of Prior Jurisdiction

AGE  
 SOCIAL SECURITY NUMBER

CITIZENSHIP/ALIEN STATUS

NM's Property (\$10,000 Exclusion)  
 Property Verification  
 Received ☐ Pending ☐

Income Verification:  
 Received ☐ Pending ☐  
 Current TILP exempt earned income ☐

TO BE COMPLETED BY PLACEMENT WORKER/COUNTY WELFARE DEPARTMENT STAFF				ELIGIBILITY WORKER ONLY
<b>15A.</b> Application: Did the NM sign a voluntary reentry agreement?				SOC 161
<b>15B.</b> Redetermination: Does the NM have a current Transitional Independent Living Plan? <input type="checkbox"/> YES <input type="checkbox"/> NO				SOC 163
<b>16.</b> What is the authority for the NM's out of home placement?				
<input type="checkbox"/> Voluntary re-entry agreement (SOC 163)		Date:		
<input type="checkbox"/> Mutual agreement (SOC 162)		Date:		
<input type="checkbox"/> Court Order of Placement and Care Vested with Agency		Date:		
Check box to indicate which court order finding was made and enter date of hearing/order.				
Court Order Findings		Petition/Order		
Finding	388 (e) Petition Hearing	6 month status review	12 month PP hearing	
<b>a).</b> Reentry and remaining in foster care in the NM's best interest		NA	NA	COURT ORDER FINDINGS MADE? Finding a: <input type="checkbox"/> Yes <input type="checkbox"/> No Finding b: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>b).</b> Reasonable efforts to finalize permanency	NA			
NM I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.				
SIGNATURE OF NM (TO BE COMPLETED BY PLACEMENT WORKER/COUNTY WELFARE DEPARTMENT IF NM UNAVAILABLE OR UNABLE TO COMPLETE AND SIGN)				<input type="checkbox"/> ELIGIBLE FACILITIES REQUIREMENTS MET
COUNTY WHERE SIGNED _____ DATE _____				
PLACEMENT WORKER COUNTY OF JURISDICTION ALL INFORMATION RECORDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.				<input type="checkbox"/> SERVICES REQUIREMENTS MET
NAME OF AGENCY _____ DATE _____				
SIGNATURE OF ELIGIBILITY WORKER _____ DATE _____				<input type="checkbox"/> NOT ELIGIBLE  <input type="checkbox"/> ELIGIBLE <input type="checkbox"/> FEDERAL <input type="checkbox"/> NONFEDERAL <input type="checkbox"/> OTHER
SIGNATURE OF ELIGIBILITY WORKER SUPERVISOR _____ DATE _____				
<b>PERSONAL INFORMATION NOTICE</b>  Pursuant to the Federal Privacy Act (P.L. 93-679) and the Information Practices Act of 1977 (Civil Code Sections 1798, et. seq.), notice is hereby given for the request of personal information by this form. The requested personal information is voluntary. The principal purpose of the voluntary information is to facilitate the processing of this form. The failure to provide all or any part of the requested information may delay processing of this form. No disclosure of personal information will be made unless permissible under Article 6, Section 1798.17 of the IPA of 1977. Each individual has the right upon request and proper identification, to inspect all personal information in any record maintained on the individual by an identifying particular. Direct any inquiries on information maintenance to your IPA Forms Officer.				